

		FOR OHF USE					

LL 1

2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: <u>0004630</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER	
Facility Name: <u>Christian Nursing Home</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>July 1, 2001</u> to <u>June 30, 2002</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.	
Address: <u>1507 - 7th Street</u> <u>Lincoln</u> <u>62656</u> Number City Zip Code		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.	
County: <u>Logan</u>		Officer or Administrator of Provider (Signed) _____ (Date) _____ (Type or Print Name) <u>Mark Havrilka</u> (Title) <u>Chief Financial Officer</u>	
Telephone Number: <u>217-732-2189</u> Fax # <u>217-732-8686</u>		Paid Preparer (Signed) _____ (Date) _____ (Print Name and Title) <u>William O. Buskirk</u> <u>CPA</u> (Firm Name & Address) <u>Eck, Schafer & Punke, LLP</u> <u>600 East Adams Springfield, IL 62701-1624</u> (Telephone) <u>217-525-1111</u> Fax # <u>217-525-1120</u>	
IDPA ID Number: <u>37-0841562004</u>		MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630	
Date of Initial License for Current Owners: <u>09/01/1965</u>			
Type of Ownership:			
<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT			
<input checked="" type="checkbox"/> Charitable Corp.		<input type="checkbox"/> PROPRIETARY	
<input type="checkbox"/> Trust		<input type="checkbox"/> Individual	
IRS Exemption Code <u>501C3</u>		<input type="checkbox"/> Partnership	
		<input type="checkbox"/> Corporation	
		<input type="checkbox"/> "Sub-S" Corp.	
		<input type="checkbox"/> Limited Liability Co.	
		<input type="checkbox"/> Trust	
		<input type="checkbox"/> Other _____	
In the event there are further questions about this report, please contact: Name: <u>William O. Buskirk</u> Telephone Number: <u>217-525-1111</u>			

STATE OF ILLINOIS

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Facility Name & ID Number Christian Nursing Home# 0004630 Report Period Beginning: July 1, 2001 Ending: June 30, 2002

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed bedsN/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>109</u>	Skilled (SNF)	<u>109</u>	<u>39,785</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>109</u>	TOTALS	<u>109</u>	<u>39,785</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>9,659</u>	<u>9,136</u>	<u>2,145</u>	<u>20,940</u>	8
9	SNF/PED					9
10	ICF	<u>7,123</u>	<u>10,329</u>		<u>17,452</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>16,782</u>	<u>19,465</u>	<u>2,145</u>	<u>38,392</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 96.50%

D. How many bed-hold days during this year were paid by Public Aid?

242 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)None

F. Does the facility maintain a daily midnight census?

YesG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☒ NO ☐

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☒ NO ☐

I. On what date did you start providing long term care at this location?

Date started 09/01/1965

J. Was the facility purchased or leased after January 1, 1978?

YES ☐ Date _____ NO ☒

K. Was the facility certified for Medicare during the reporting year?

YES ☒ NO ☐ If YES, enter number
of beds certified 11 and days of care provided 4,015Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED
CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 06/30/2002 Fiscal Year: 06/30/2002

* All facilities other than governmental must report on the accrual basis.

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Facility Name & ID Number

Christian Nursing Home

0004630

Report Period Beginning: July 1, 2001

Ending: June 30, 2002

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	160,833	29,899	12,047	202,779		202,779		202,779		1
2	Food Purchase		203,185		203,185		203,185	(175)	203,010		2
3	Housekeeping	120,598	21,854		142,452		142,452		142,452		3
4	Laundry	40,331	15,737		56,068		56,068		56,068		4
5	Heat and Other Utilities			110,687	110,687		110,687	3,027	113,714		5
6	Maintenance	72,357	19,980	30,794	123,131		123,131	6,226	129,357		6
7	Other (specify):*										7
8	TOTAL General Services	394,119	290,655	153,528	838,302		838,302	9,078	847,380		8
	B. Health Care and Programs										
9	Medical Director										9
10	Nursing and Medical Records	1,706,014	158,946	85,549	1,950,509		1,950,509		1,950,509		10
10a	Therapy			280,593	280,593		280,593		280,593		10a
11	Activities	21,968			21,968		21,968	(898)	21,070		11
12	Social Services	93,428	1,000	6,828	101,256		101,256		101,256		12
13	Nurse Aide Training										13
14	Program Transportation		1,761		1,761		1,761		1,761		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,821,410	161,707	372,970	2,356,087		2,356,087	(898)	2,355,189		16
	C. General Administration										
17	Administrative	82,813	2,073	182,976	267,862		267,862	(131,803)	136,059		17
18	Directors Fees										18
19	Professional Services			4,929	4,929		4,929	11,672	16,601		19
20	Dues, Fees, Subscriptions & Promotions			25,053	25,053		25,053	(7,721)	17,332		20
21	Clerical & General Office Expenses	49,611	7,685	56,958	114,254		114,254	21,042	135,296		21
22	Employee Benefits & Payroll Taxes			417,136	417,136		417,136	18,994	436,130		22
23	Inservice Training & Education										23
24	Travel and Seminar			12,418	12,418		12,418	5,419	17,837		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			50,897	50,897		50,897	2,267	53,164		26
27	Other (specify):*										27
28	TOTAL General Administration	132,424	9,758	750,367	892,549		892,549	(80,130)	812,419		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,347,953	462,120	1,276,865	4,086,938		4,086,938	(71,950)	4,014,988		29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

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Facility Name & ID Number

Christian Nursing Home

#0004630

Report Period Beginning:

July 1, 2001

Ending:

June 30, 2002

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			192,921	192,921		192,921	11,255	204,176			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			66,637	66,637		66,637	(32,239)	34,398			32
33	Real Estate Taxes			952	952		952		952			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			260,510	260,510		260,510	(20,984)	239,526			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			8,412	8,412		8,412		8,412			38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops			13,042	13,042		13,042		13,042			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			59,677	59,677		59,677		59,677			42
43	Other (specify):* Apt & Cong			458,212	458,212		458,212	(3,176)	455,036			43
44	TOTAL Special Cost Centers			539,343	539,343		539,343	(3,176)	536,167			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,347,953	462,120	2,076,718	4,886,791		4,886,791	(96,110)	4,790,681			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

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Facility Name & ID Number Christian Nursing Home

0004630

Report Period Beginning:

July 1, 2001

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VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(666)	5		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	3,764	30		9
10	Interest and Other Investment Income	(42,596)	32		10
11	Discounts, Allowances, Rebates & Refunds	(1,328)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest	(3,176)	43		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(33,182)	21		24
25	Fund Raising, Advertising and Promotional	(7,721)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Attached	7,687			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (77,218)		\$	30

OHF USE ONLY						
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
	Amortization of Organization &			
33	Pre-Operating Expense			33
	Adjustments for Related Organization			
34	Costs (Schedule VII)	(18,892)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (18,892)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (96,110)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

Christian Nursing HomeID# 0004630Report Period Beginning: July 1, 2001Ending: June 30, 2002

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Vending Machine Income	\$ (175)	2	1
2	Activity Revenue	(898)	11	2
3	Loss on Sale of Equipment	403	17	3
4	Miscellaneous Revenue	(2,000)	17	4
5	Prior Year Deferred Bond Cost Expense	10,357	32	5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	7,687		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Christian Nursing Home

0004630

Report Period Beginning:

July 1, 2001

Ending:

June 30, 2002

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(175)	0	0	0	0	0	0	0	0	0	0	(175)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(666)	3,693	0	0	0	0	0	0	0	0	0	3,027	5
6	Maintenance	0	6,226	0	0	0	0	0	0	0	0	0	6,226	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(841)	9,919	0	0	0	0	0	0	0	0	0	9,078	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(898)	0	0	0	0	0	0	0	0	0	0	(898)	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(898)	0	0	0	0	0	0	0	0	0	0	(898)	16
	C. General Administration													
17	Administrative	(1,597)	(130,206)	0	0	0	0	0	0	0	0	0	(131,803)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	11,672	0	0	0	0	0	0	0	0	0	11,672	19
20	Fees, Subscriptions & Promotions	(7,721)	0	0	0	0	0	0	0	0	0	0	(7,721)	20
21	Clerical & General Office Expenses	(34,510)	55,552	0	0	0	0	0	0	0	0	0	21,042	21
22	Employee Benefits & Payroll Taxes	0	18,994	0	0	0	0	0	0	0	0	0	18,994	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	5,419	0	0	0	0	0	0	0	0	0	5,419	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	2,267	0	0	0	0	0	0	0	0	0	2,267	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(43,828)	(36,302)	0	0	0	0	0	0	0	0	0	(80,130)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(45,567)	(26,383)	0	0	0	0	0	0	0	0	0	(71,950)	29

Facility Name & ID Number Christian Nursing Home# 0004630Report Period Beginning: July 1, 2001 Ending: June 30, 2002

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached Schedule						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
1	V	5 Utilities	\$	Christian Homes Inc	100.00%	\$ 3,693	\$ 3,693 1
2	V	6 Maintenance				6,226	6,226 2
3	V	17 Administrative	182,976			52,770	(130,206) 3
4	V	18 Directors					
5	V	19 Professional Services				11,672	11,672 5
6	V	20 Fees/Subscriptions/Promo					
7	V	21 Clerical				55,552	55,552 7
8	V	22 Employee Benefits				18,994	18,994 8
9	V	23 Inservice					
10	V	24 Travel & Seminar				5,419	5,419 10
11	V	26 Insurance				2,267	2,267 11
12	V	30 Depreciation				7,491	7,491 12
13	V						
14	Total		\$ 182,976			\$ 164,084	\$ * (18,892) 14

* Total must agree with the amount recorded on line 34 of Schedule VI.

STATE OF ILLINOIS

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Facility Name & ID Number Christian Nursing Home # 0004630 Report Period Beginning: July 1, 2001 Ending: June 30, 2002

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
1	This workpaper is not applicable.								\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME,
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Christian Nursing Home# 0004630 Report Period Beginning:

July 1, 2001

Ending: ne 30, 2002

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	<u>This workpaper is not applicable</u>				\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3		4		5		6		7		8		9		10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense								
		YES	NO				Original	Balance											
	A. Directly Facility Related																		
	Long-Term																		
1	1993-A GR Bonds	x		Debt Restructure		01/01/93	\$ 450,000	\$		01/01/18	0.0750	\$ 29,384	1						
2	1991-C GR Bonds	x		Debt Restructure		07/01/93	573,010				0.0775	36,549	2						
3													3						
4													4						
5													5						
	Working Capital																		
6	CHI Bond Fund	x		Working Capital								704	6						
7													7						
8													8						
9	TOTAL Facility Related							\$ 1,023,010	\$					\$ 66,637	9				
	B. Non-Facility Related*																		
10	1993-A GR Bonds			Debt Restructure		01/01/93	50,000			01/01/18	0.0750	3,265	10						
11													11						
12													12						
13													13						
14	TOTAL Non-Facility Related							\$ 50,000	\$					\$ 3,265	14				
15	TOTALS (line 9+line14)							\$ 1,073,010	\$					\$ 69,902	15				

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ _____ Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Christian Nursing Home COUNTY Logan

FACILITY IDPH LICENSE NUMBER 004630

CONTACT PERSON REGARDING THIS REPORT Brenda Lavin

TELEPHONE 217-732-9651 FAX #: 217-732-8686

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2001.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>12-036-031-00</u>	<u>12-704 S36 T20 R3</u>	\$ <u>698.42</u>	\$ _____
2. <u>12-623-005-00</u>	<u>12-3054</u>	\$ <u>237.84</u>	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>936.26</u>	\$ <u> </u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES x NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet:
 40,088

B. General Construction Type:
 Exterior
 Masonry
 Frame
 Steel
 Number of Stories
 1

C. Does the Operating Entity?
 ☒ (a) Own the Facility
 ☐ (b) Rent from a Related Organization.
 ☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?
 ☒ (a) Own the Equipment
 ☐ (b) Rent equipment from a Related Organization.
 ☐ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

Apartments

Congregate Building

Duplexes.

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?
 ☐ YES
 ☒ NO

If so, please complete the following:

1. Total Amount Incurred:
 None

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility	43,560	Various	\$ 83,965	1
2	Home Office			7,243	2
3	TOTALS	43,560		\$ 91,208	3

Facility Name & ID Number Christian Nursing Home

0004630

Report Period Beginning:

July 1, 2001 Ending: June 30, 2002

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
Bed*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	48	1965	1965	\$ 272,125	\$ 6,411	40	\$ 6,803	\$ 392	\$ 219,005
5	26	1969	1969	282,500	6,637	36	7,847	1,210	230,698
6	26	1972	1972	318,878	7,501	33	9,663	2,162	251,232
7	9	2000		1,279,292	31,982	40	31,982		55,969
8	Home Office			78,759	1,517		1,517		42,795
Improvement Type**									
9	Building Improvement	1965		48,022		20			
10	Building Improvement	1969		49,853		20			
11	Building Improvement	1972		56,049		20			
12	Insulation/Fire Doors	1979		11,989	266	45	266		6,140
13	Windows & Improvements	1980		36,891	1,054	35	1,054		24,242
14	Water SENTRY	1980		604		5			604
15	Furnace	1981		2,005		15			2,005
16	Laundry Room	1981		4,253	125	34	125		2,688
17	Folding Door	1982		429	21	20	21		422
18	Cooling Unit	1982		7,070		15			7,070
19	Garage	1982		2,875		15			2,875
20	Roofing	1982		9,373		5			9,373
21	Heating Control System	1983		8,969		15			8,969
22	Fan	1983		243		10			243
23	Roof Repairs	1983		34,602		15			34,602
24	Office Lights	1984		487		10			487
25	Water Heaters	1984		2,661		15			2,661
26	A/C Units	1984		12,415		8			12,415
27	Kitchen Doors	1984		2,008	100	20	100		1,808
28	Compartment	1984		264		10			264
29	Wallpapering	1985		5,014		5			5,014
30	Roof Repairs	1985		50,063		5			50,063
31	Glazing Panels	1985		17,986	719	25	719		12,223
32	Windows	1985		7,800	223	35	223		3,791
33	Condensing Unit	1985		1,735		10			1,735
34	Cabinet & Sink Tops	1986		2,302	7	15	7		2,302
35	Building Improvement	1986		8,250	330	25	330		5,335
36	Gravel Roof	1986		2,986		15			2,986

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37	Access Panel	1986	\$ 111	\$ 6	20	\$ 6		\$ 96		37
38	A/C Unit	1986	10,500	525	20	525		8,356		38
39	Wall Cabinet	1986	191		10			191		39
40	Laundry Floor Cover	1986	1,157		5			1,157		40
41	Drapes	1986	2,282		5			2,282		41
42	Laundry Room	1986	26,110	1,306	20	1,306		20,355		42
43	Laundry Floor	1987	3,196		5			3,196		43
44	Sprinkler System	1987	120	6	20	6		92		44
45	Wall Bumper	1987	211	11	20	11		168		45
46	Fire Alarm	1987	499	25	20	25		382		46
47	Life Safety Work	1987	9,104	455	20	455		6,939		47
48	Life Safety	1987	266	27	10	27		235		48
49	Shuttering	1987	893	45	20	45		679		49
50	Wallcovering	1987	285		5			285		50
51	Carpeting	1987	1,817		5			1,817		51
52	Beauty Shop Floor	1987	618		5			618		52
53	Remodeling	1987	200	20	10	20		180		53
54	Life Safety	1987	1,284	84	10	84		1,284		54
55	Chaplains Office	1987	667		5			667		55
56	Life Safety	1987	1,875	188	10	188		1,700		56
57	Cabinets Beauty Shop	1987	558	37	15	37		549		57
58	Glass Windows	1987	2,396	120	20	120		1,770		58
59	Lights	1987	364		10			364		59
60	Metal Door	1987	440	22	20	22		321		60
61	Water Heater	1987	4,701		10			4,701		61
62	3-Ply Pitch Roof	1988	6,150	410	15	410		5,638		62
63	New A/C Work	1989	6,066	303	20	303		4,091		63
64	A/C System	1989	42,748	2,137	20	2,137		28,671		64
65	Ceiling Tiles	1989	351		5			351		65
66	Fire Dampers	1989	1,881		10			1,881		66
67	Replace Door	1989	657	33	20	33		426		67
68	Condensing Unit	1989	700		5			700		68
69	Sprinkler System	1989	4,106	205	20	205		2,631		69
70	TOTAL (lines 4 thru 69)		\$ 2,751,256	\$ 62,858		\$ 66,622	\$ 3,764	\$ 1,102,789		70

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12A, Carried Forward		\$ 2,751,256	\$ 62,858		\$ 66,622	\$ 3,764	\$ 1,102,789		1
2	Life Safety	1989	458	46	10	46		456		2
3	Stain Glass Windows	1989	475		10			475		3
4	Remodel Dining Room	1990	2,970		10			2,970		4
5	Circulating Pump	1990	705	47	15	47		572		5
6	Replace /Install Window	1990	710	20	35	20		242		6
7	Doors	1990	508	25	20	25		298		7
8	Roofing A/C	1990	1,732	115	15	115		1,370		8
9	Water Heater	1990	2,275	152	15	152		1,799		9
10	A/C Unit	1990	10,186		10			10,186		10
11	Wallpaper	1991	2,544		5			2,544		11
12	Modular Nurse Station	1991	9,321		10			9,321		12
13	Roll Cover Base	1991	599		10			599		13
14	Wallpaper	1991	1,807		5			1,807		14
15	Wallcoverings	1991	5,774		5			5,774		15
16	A/C Compressor	1991	7,007		10			7,007		16
17	Cafeteria Window	1991	711	20	35	20		222		17
18	Base Cabinet	1991	666	44	15	44		473		18
19	Roof Work	1991	2,900	193	15	193		2,059		19
20	Water Heater	1991	1,288	86	15	86		910		20
21	Remodeling 32 Rooms	1992	25,027	1,251	20	1,251		13,031		21
22	Life Safety	1992	814	81	20	81		704		22
23	Doors (5)	1992	2,550	128	20	128		1,312		23
24	Smoke Heads Fire Relay	1992	1,235	62	20	62		636		24
25	Cove Base (120')	1992	591	50	10	50		591		25
26	Install Sprinklers	1992	1,382	69	20	69		701		26
27	Life Safety	1992	973	97	20	97		826		27
28	Furnaces	1992	13,165	658	20	658		6,416		28
29	Wall Paper	1992	3,376		5			3,376		29
30	Carpeting	1993	5,313		5			5,313		30
31	Lighting	1993	954	95	10	95		887		31
32	Air Conditioner	1993	4,475	448	10	448		4,069		32
33	Reroof	1993	8,477	385	22	385		3,497		33
34	TOTAL (lines 1 thru 33)		\$ 2,872,224	\$ 66,930		\$ 70,694	\$ 3,764	\$ 1,193,232		34

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12B, Carried Forward		\$ 2,872,224	\$ 66,930		\$ 70,694	\$ 3,764	\$ 1,193,232		1
2	SW Roof	1993	900	41	22	41		362		2
3	Furnaces	1993	4,570	229	20	229		1,985		3
4	Lighting Life Safety	1994	973	97	10	97		800		4
5	Panels/Base Dayroom	1994	860		5			860		5
6	Drive Up/Curb Canopy	1994	7,108	711	10	711		5,806		6
7	Door Alarms	1994	851		5			851		7
8	Doors	1994	1,319	132	10	132		1,045		8
9	Front Entrance	1995	11,006	1,101	10	1,101		7,615		9
10	Roof	1995	6,300		5			6,300		10
11	Roof	1995	15,582	1,558	10	1,558		10,517		11
12	Front Entrance	1996	7,125	713	10	713		4,575		12
13	Roof Work	1996	3,400		5			3,400		13
14	Cnds. Unit-100	1996	2,742	274	10	274		1,667		14
15	Roof Work	1996	536	10	5	10		536		15
16	Roof Work Ewing	1996	3,062	155	5	155		3,062		16
17	Roof Repairs	1996	1,279	84	5	84		1,279		17
18	Lights & Dampers	1997	17,712	1,771	10	1,771		9,593		18
19	Courtyard Door	1997	972	97	10	97		477		19
20	Office Roof Work	1997	2,275	455	5	455		2,199		20
21	Roof Work 100 Wing	1997	13,120	1,312	10	1,312		6,341		21
22	Floor Covering	1997	2,091	418	5	418		1,951		22
23	Roof Work N&S Wing	1998	12,500	1,250	10	1,250		5,208		23
24	South Wing Roof Work	1998	14,800	1,480	10	1,480		5,969		24
25	A/C in Lobby	1998	1,226	123	10	123		502		25
26	Compressor - Laundry	1998	1,914		3			1,914		26
27	Roof Work	1999	1,920	384	5	384		1,536		27
28	Roof Work - Valley Area	1999	5,073	1,015	5	1,015		3,975		28
29	Carpeting 300 Wing	1999	11,167	2,233	5	2,233		8,374		29
30	A/C Unit 300 Wing	1999	4,284	428	10	428		1,605		30
31	Roof Work Dining Area	1999	6,590	1,318	5	1,318		4,943		31
32	Wallpaper 300 Wing	1999	12,512	2,502	5	2,502		8,965		32
33	Carpet Conference	1999	978	196	5	196		719		33
34	TOTAL (lines 1 thru 33)		\$ 3,048,971	\$ 87,017		\$ 90,781	\$ 3,764	\$ 1,308,163		34

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 3,048,971	\$ 87,017		\$ 90,781	\$ 3,764	\$ 1,308,163	1
2	Carpet Lobby	1999	5,021	1,004	5	1,004		3,681	2
3	Carpeting	1999	3,473	695	5	695		2,433	3
4	Office A/C Unit	1999	2,715	272	10	272		929	4
5	Carpeting	1999	1,743	349	5	349		1,163	5
6	Roof Work	1999	3,665	733	5	733		2,382	6
7	Remodel Beauty Shop	1999	1,339	268	5	268		849	7
8	Roof work	2000	5,536	1,107	5	1,107		3,229	8
9	Opto 22 energy management	2000	14,795	986	15	986		2,712	9
10	AD Smith water heater	2000	3,195	320	10	320		880	10
11	Water heater	2000	5,590	559	10	559		1,444	11
12	Handwash station	2000	1,140	76	15	76		190	12
13	Kitchen expansion	2000	790,605	19,765	40	19,765		46,118	13
14	Wallcover Staff DR	2000	933	187	5	187		436	14
15	Storage cabs	2000	676	45	15	45		105	15
16	Condensing unit	2000	2,530	169	15	169		366	16
17	Compressor laundry	2000	1,524	127	15	127		275	17
18	Heaters in Dayroom	2000	1,029	69	15	69		115	18
19	Wallpaper Secretary Office	2001	2,943	589	5	589		834	19
20	Alzheimers Addition	2000	90,006	2,250	40	2,250		3,938	20
21	NURSE CALL SYSTEM	2001	26,200	2,620	10	2,620		3,712	21
22	80 LIGHT FIXTURES INSTALLED	2001	5,000	500	10	500		708	22
23	12 SMOKE DETECTORS	2001	1,504	150	10	150		200	23
24	5 TON CONDENSING UNIT (100 WING)	2001	1,599	160	10	160		173	24
25	Alzheimers Addition (See Bldg Page 12)								25
26	3 Swinging Fire Doors W/ Frames	2001	700	70	10	70		70	26
27	Vinyl For Various Ares	2001	4,400		5				27
28	Sprinkler System(Kitchen/Dining Rm Area)	2001	565	57	10	57		57	28
29	Compressors Etc, 300 Wing	2001	1,732	577	3	577		577	29
30	3 Swinging Fire Doors W/ Frames	2001	12,304	923	10	923		923	30
31	Main Breaker - NH	2001	4,718	315	10	315		315	31
32	Vinyl For Various Ares	2001	8,528	995	5	995		995	32
33	Carpeting - Activity Room	2001	15,290	1,784	5	1,784		1,784	33
34	TOTAL (lines 1 thru 33)		\$ 4,069,969	\$ 124,738		\$ 128,502	\$ 3,764	\$ 1,389,756	34

**Improvement type must be detailed in order for the cost report to be considered complete.

July 1, 2001 Ending: June 30, 2002

****Improvement type must be detailed in order for the cost report to be considered complete.**

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 609,570	\$ 65,053	\$ 65,053	\$	Various	\$ 255,433	71
72	Current Year Purchases	44,388	3,588	3,588		Various	3,588	72
73	Fully Depreciated Assets	169,829					169,829	73
74	Home Office Allocation	78,759	3,411	3,411			42,795	74
75	TOTALS	\$ 902,546	\$ 72,052	\$ 72,052	\$		\$ 471,645	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Patient Transportation	1992 Bus	1992	\$ 38,828	\$	\$	\$	8	\$ 38,828	76
77	Patient Transportation	1984 Mercury Gran Marquis	1984	2,291				3	2,291	77
78	Patient Transportation	1985 Chevy Van	1998	4,300				3	4,300	78
79	Home Office Allocation			9,279	2,562	2,562			6,487	79
80	TOTALS			\$ 54,698	\$ 2,562	\$ 2,562	\$		\$ 51,906	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 5,150,182	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 200,412	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 204,176	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 3,764	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,909,967	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Apartment	\$ 436,464	\$ 15,882	\$ 297,556	86
87	Congregate	2,054,877	57,867	928,959	87
88	Land	314,369			88
89	Land Improvements	160,456	4,119	129,970	89
90	DQ	1,735,707	54,616	724,461	90
91	TOTALS	\$ 4,701,873	\$ 132,484	\$ 2,080,946	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Not Applicable

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

☐ YES ☐ NO

16. Rental Amount for movable equipment: \$ Description:

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning

Ending

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. /2003 \$

13. /2004 \$

14. /2005 \$

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?	<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	2. CLASSROOM PORTION:	3. CLINICAL PORTION:
If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.		IN-HOUSE PROGRAM <input type="checkbox"/>	IN-HOUSE PROGRAM <input type="checkbox"/>
		IN OTHER FACILITY <input checked="" type="checkbox"/>	IN OTHER FACILITY <input checked="" type="checkbox"/>
		COMMUNITY COLLEGE <input type="checkbox"/>	HOURS PER AIDE <u>40</u>
		HOURS PER AIDE <u>87.5</u>	

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	2,700	\$	2,700
2	Books and Supplies		375		375
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	3,075	\$	3,075
10	SUM OF line 9, col. 1 and 2 (e)	\$	3,075		

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	15
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	15

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist	This Workpaper is not applicable.	hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)									
10			hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			\$		\$	\$		\$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 297,146	\$	1
2	Cash-Patient Deposits	2,252		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 41,288)	618,931		3
4	Supply Inventory (priced at)	18,160		4
5	Short-Term Investments	531,471		5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Other A/R	14,444		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,482,404	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	314,369		13
14	Buildings, at Historical Cost	7,993,913		14
15	Leasehold Improvements, at Historical Cost	202,689		15
16	Equipment, at Historical Cost	1,083,063		16
17	Accumulated Depreciation (book methods)	(3,905,236)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	1,799,189		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 7,487,987	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 8,970,391	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 239,245	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	157,116		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	468		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 396,829	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	945,500		41
42	Deferred Compensation	738,009		42
	Other Long-Term Liabilities(specify):			
43	Funds in Trust/Security Deposits	801,983		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 2,485,492	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,882,321	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 6,088,070	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 8,970,391	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 5,370,219	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 5,370,219	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,368,204	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) PY Deferred Bond Cost Expense	(10,357)	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 1,357,847	17
	B. Transfers (Itemize):		
18	Transfer to Affiliate Home	(639,996)	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ (639,996)	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 6,088,070	24 *

* This must agree with page 17, line 47.

VII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 5,251,014	1
2	Discounts and Allowances for all Levels	(539,572)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,711,442	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	1,073	12
13	Barber and Beauty Care	12,756	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 13,829	23
	D. Non-Operating Revenue		
24	Contributions	742,253	24
25	Interest and Other Investment Income***	130,847	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 873,100	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Residential & Congregate	642,923	28
28a	Unrealized G(L) on Sale of Equip & Investments	13,701	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 656,624	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,254,995	30

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	838,302	31
32	Health Care	2,356,087	32
33	General Administration	892,549	33
	B. Capital Expense		
34	Ownership	260,510	34
	C. Ancillary Expense		
35	Special Cost Centers	479,666	35
36	Provider Participation Fee	59,677	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,886,791	40
41	Income before Income Taxes (line 30 minus line 40)**	1,368,204	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,368,204	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Christian Nursing Home# 0004630Report Period Beginning: July 1, 2001Ending: June 30, 2002

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,793	2,303	\$ 64,289	\$ 27.92	1
2	Assistant Director of Nursing	1,802	2,339	48,583	20.77	2
3	Registered Nurses	5,062	6,701	167,731	25.03	3
4	Licensed Practical Nurses	30,569	32,581	545,210	16.73	4
5	Nurse Aides & Orderlies	78,256	84,421	839,372	9.94	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,394	3,394	40,829	12.03	8
9	Activity Director					9
10	Activity Assistants					10
11	Social Service Workers	12,044	12,723	115,396	9.07	11
12	Dietician					12
13	Food Service Supervisor	1,694	1,759	17,874	10.16	13
14	Head Cook					14
15	Cook Helpers/Assistants	17,126	17,650	142,959	8.10	15
16	Dishwashers					16
17	Maintenance Workers	5,400	5,625	72,357	12.86	17
18	Housekeepers	13,450	14,201	120,598	8.49	18
19	Laundry	4,320	4,455	40,331	9.05	19
20	Administrator	1,732	1,972	82,813	41.99	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,736	1,797	20,846	11.60	23
24	Clerical	2,864	2,944	28,765	9.77	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	181,242	194,865	\$ 2,347,953 *	\$ 12.05	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	282	\$ 12,047	1.3	35
36	Medical Director	3	800	10A.3	36
37	Medical Records Consultant	18	2,905	10.3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	120	1,300	10.3	39
40	Physical Therapy Consultant	2,911	158,420	10A.3	40
41	Occupational Therapy Consultant	1,980	106,070	10A.3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	280	14,503	10A.3	43
44	Activity Consultant				44
45	Social Service Consultant	49	2,928	12.3	45
46	Other(specify) <u>UR Committee Fees</u>		800	10A.3	46
47	<u>Dental Consultant</u>		(35)	10.3	47
48					48
49	TOTAL (lines 35 - 48)	5,643	\$ 299,738		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		\$		53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				Ownership		D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	%	Amount	Description		Amount	Description	Amount		
Dick Warren	Administrator	0%	\$ 82,813	Workers' Compensation Insurance		\$ 69,964	IDPH License Fee	\$		
				Unemployment Compensation Insurance		5,712	Advertising: Employee Recruitment	4,797		
				FICA Taxes		170,120	Health Care Worker Background Check (Indicate # of checks performed _____)			
				Employee Health Insurance		160,300	Support & Online Fee	4,289		
				Employee Meals			Software Maintenance Fees	1,342		
				Illinois Municipal Retirement Fund (IMRF)*			Annual & Remote Line Fees	199		
				Employee Expense		7,404	Miscellaneous Dues & Fees	366		
				Employee Physicals & Dental		3,636	Professional Dues	6,339		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)					\$	82,813				
B. Administrative - Other										
Description			Amount							
Management Fee			\$ 182,976	Home Office Allocation		18,994				
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)					\$	436,130	TOTAL (agree to Sch. V, line 20, col. 8) \$ 17,332			
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees						
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount		
Van Ostrand	Legal Services		\$ 3,701				Out-of-State Travel	\$		
Booth & Antoline	Legal Services		1,228							
							In-State Travel	1,566		
							Seminar Expense	8,649		
							Other Costs	2,203		
							Home Office Allocation	5,419		
							Entertainment Expense	(
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)				TOTAL (agree to Sch. V, line 24, col. 8) \$ 17,837						
			\$ 4,929							

* Attach copy of IMRF notifications

****See instructions.**

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

[illegible]

Facility Name & ID Number Christian Nursing Home

STATE OF ILLINOIS

0004630

Report Period Beginning: July 1, 2001

Page 23

Ending: June 30, 2001

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN, LPN, NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. LSN - \$6,130.
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 12,628 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES x NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO x If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 59,677
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? Yes For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? No Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? _____
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? _____
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ 0
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Eck, Schafer & Punke, LLP The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? No If no, please explain. Will send when completed
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.

Summary of Employee Expenses
The Christian Village 6/30/2002

<u>Fica</u>	<u>Unemploy</u>	<u>Workers Compen</u>	<u>Health Ins</u>	<u>Benefit Percent</u>	<u>Employee Expense</u>	<u>Employee Physical</u>	<u>Employee Bonus</u>	
123,194	3,840	47,100	105,350	81,980				
11,791	552	6,684	13,650	5,301				
9,131	432	5,268	12,950	4,830				
2,577	132	1,596		1,222				
4,936	180	2,200	11,900	3,197				
8,947	384	4,740	12,250	3,588				
9,522	192	2,376	4,200		7,404	3,578	8,458	
				8,458	58		-8,458	
170,098	5,712	69,964	160,300	108,576	7,462	3,578	0	525,690
22								-108,576
170,120								417,114
						3.22.3		417,136
						Rounding		22